DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 7 — 1 4

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
August 5, 1997

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR

7. FEDERAL BUDGET IMPACT:
a. FFY 98 $ 0
b. FFY $

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19D
Pages 1-247
Appendix 4.19D Pages 1-6

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19D
Pages 1-195
Appendix 4.19D pages 1-5

10. SUBJECT OF AMENDMENT:
Nursing Facility State Plan Amendment

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Gary J. Stangler

14. TITLE:
Director, Dept. of Social Services

15. DATE SUBMITTED:
9-29-97

16. RETURN TO:
Division of Medical Services
615 Howerton Court
Jefferson City, MO 65109

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 30, 1997

18. DATE APPROVED:
JUN 26 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid and State Operations

REMARKS:
Martin

FORM HCFA-179 (07-92)

Instructions on Back

STATE OF MISSOURI
Department of Social Services
Division of Medical Services
Nursing Home Program

Prospective Reimbursement Plan for Nursing Facility Services

(1) Authority. This plan is established pursuant to the authorization granted to the Department of Social Services (Department), Division of Medical Services (Division).

(2) Purpose. This plan establishes a methodology for determination of reimbursement rates for nursing facilities. Subject to limitations prescribed elsewhere in this plan, a facility's reimbursement rate shall be determined by the Division as described in this plan. Any reimbursement rate determined, by the Division, that has been appealed in a timely manner shall not be final until there is a final decision. Federal financial participation is available on expenditures for services provided within the scope of the Federal Medicaid Program and made under a court order in accordance with 42 CFR 431.250.

(3) General Principles.

(A) Provisions of this reimbursement plan shall apply only to facilities certified for participation in the Missouri Medical Assistance (Medicaid) Program.

(B) The reimbursement rates determined by this plan shall apply only to services provided on or after January 1, 1995.

(C) The effective date of this plan shall be January 1, 1995.

(D) The Medicaid Program shall provide reimbursement for nursing facility services based solely on the individual Medicaid eligible recipient's covered days of care, within benefit limitations as determined in subsections (5)(D) and (5)(M) multiplied by the facility's Medicaid reimbursement rate. No payments may be collected or retained in addition to the Medicaid

reimbursement rate for covered services, unless otherwise provided for in this plan. Where third party payment is involved, Medicaid will be the payor of last resort with the exception of state programs such as Vocational Rehabilitation and the Missouri Crippled Children's Services.

(E) The Medicaid reimbursement rate shall be the lower of:

1. The Medicare (Title XVIII) rate, if applicable; or

2. The reimbursement rate as determined in accordance with sections (11), (12) and (13).

(F) Medicaid reimbursements shall not be paid for services provided to Medicaid eligible recipients during any time period in which the facility failed to have a Medicaid participation agreement in effect. A reimbursement rate may not be established for a facility if a Medicaid participation agreement is not in effect.

(G) When a nursing facility is found not in compliance with federal requirements for participation in the Medicaid program, Sections 1919 (b), (c) and (d) of the Social Security Act (42 USC 1396r), it may be terminated from the Medicaid program or it may have imposed upon it an alternative remedy, pursuant to Section 1919 (h) of the Social Security Act (42 USC 1396r). In accordance with Section 1919 (h)(3)(D) of the Social Security Act, the alternative remedy, denial of payment for new admission, is contingent upon agreement to repay payments received if the corrective action is not taken in accordance with the approved plan and timetable. It is also required that the nursing facility establish a directed plan of correction in conjunction with and acceptable to the Division of Aging.

(H) Upon execution of a Medicaid participation agreement, a qualified facility not previously certified for participation in the Medicaid Program shall be assigned a provider number by the Division. Facilities previously certified shall retain the same provider number and interim or prospective rate regardless of any change in ownership.

(I) Regardless of changes in control or ownership for any facility certified for participation in the Medicaid Program, the Division shall issue payments to the facility identified in the current Medicaid participation agreement. Regardless of changes in control or ownership for any facility certified for participation in Medicaid, the Division shall recover from that entity liabilities, sanctions and penalties pertaining to the Medicaid Program, regardless of when the services were rendered.

(J) Changes in ownership, management, control, operation, leasehold interest by whatever form for any facility previously certified for participation in the Medicaid program at any time that results in increased capital costs for the successor owner, management or leaseholder shall not be recognized for purposes of reimbursement;

(K) A facility with certified and non-certified beds shall allocate allowable costs related to the provision of nursing facility services on the cost report, in accordance with the cost report instructions. The methods for allocation must be supported by adequate accounting and/or statistical data necessary to evaluate the allocation method and its application.

(L) Any facility which is involuntarily terminated from participation in the Medicare Program shall also be terminated from participation in the Medicaid Program on the same date as the Medicare termination.

(M) No restrictions nor limitations shall, unless precluded by state plan, be placed on a recipient's right to select providers of his/her own choice.

(N) The average Medicaid reimbursement rate paid shall not exceed the average private pay rate for the same period covered by the facility's Medicaid cost report. Any amount in excess will be subject to repayment and/or recoupment. The comparison of the average Medicaid reimbursement rate paid to the average private pay rate paid will not result in a repayment and/or recoupment until a facility has filed a cost report with a fiscal year ending after January 1, 1999. For example, a nursing facility with a December 31, 1998, year end cost report would not be used in the private pay rate comparison while a cost report ending on January 31, 1999, would be used in this comparison. This comparison will not be performed for any nursing facility licensed under Chapter 198, RSMo and operated by a district or county and receives local tax revenues.

(O) The reimbursement rates authorized by this plan shall be reevaluated at least on an annual basis in light of the provider's cost experience to determine any adjustments needed to assure coverage of cost increases that must be incurred by efficiently and economically operated providers.

(P) Covered supplies, such as but not limited to, food, laundry supplies, housekeeping supplies, linens, and medical supplies, must be accounted for through inventory accounts. Purchases shall be recorded as inventory and shall be expensed in the fiscal year the items are used. Inventory shall be counted at least annually to coincide with the facility's fiscal year or the end of the cost report period, if different. Expensing of items shall be recorded by adding purchases to the beginning period inventory and subtracting the end of the period inventory. This inventory control shall begin the first fiscal year ending after the effective date of this plan.

(Q) Medicaid reimbursement will not be paid for a Medicaid eligible resident while placed in a non-certified bed in a nursing facility.

(R) All illustrations and examples provided throughout this plan are for illustration purposes only and are not meant to be actual calculations.

(S) Each state fiscal year the Department shall submit to the Office of Administration for consideration a budget item based on the HCFA Market Basket Index for Nursing Homes representing a statistical measure of the change in costs of goods and services purchased by nursing facilities during the course of one year. Each year, an amendment to section (13)(A) of the state plan will be filed that will contain the specific details of the trend approved for that year, including the amount, basis and effective date of the trend.

The submission of the budget item by the Department has no correlation to determining the costs that are incurred by an efficiently and economically operated facility. Any trend factor granted shall be applied to the patient care, ancillary and administration cost components. For facilities with allowable costs from the their 1992 desk audited and/or field audited cost report as determined in sections (11), (12) and (13) of this plan that are below the facilities' January 1, 1994, reimbursement rate, any granted trend factor shall be limited to the product of the new plan rate divided by the January 1, 1994, (old plan rate) times the facility's trend factor. For example:

New Plan Rate (1-1-95)	$49.19
January 1, 1994, Rate	$54.32
Proposed Trend Factor	$ 1.88
Adjusted Trend Factor	$ 1.70

($49.19/$54.32) * $1.88
90.55% * $1.88 = $1.70

The rate after the trend would be $56.02 ($54.32+$1.70).

(T) Rebasing.

(1) The Division shall pick at least one cost report year from cost reports with fiscal years ending in 1995 through 1999 to compare the allowable costs from the selected desk audited and/or field audited cost report year to the reimbursement rate in effect at the time of the comparison. Each facilities' reimbursement rate will be increased or decreased to reflect the allowable costs from the desk audited and/or field audited cost report selected above.

(2) The asset value will be adjusted annually based on the R. S. Means Construction index. The asset value as adjusted will be used only for determining reimbursement in section (11) for the year or years selected above for rebasing and as determined in sections (13)(B)6. and (13)(B)7.

(4) Definitions.

(A) Additional Beds. Newly constructed beds never certified for Medicaid or never previously licensed by the Division of Aging or Department of Health.

(B) Administration. This cost component includes the following lines from the cost report version MSIR-1 (7-93): lines 105, 113-120, 122-140, 142-144, 147-150, 152-158 and amortization of organizational costs reported on line 106.

(C) Age of Beds. The age is determined by subtracting the initial licensing year from 1994 or the current year, if later.

(D) Allowable Cost. Those costs which are allowable for allocation to the Medicaid Program based upon the principles established in this plan. The allowability of costs shall be determined by the Division of Medical Services and shall be based upon criteria and principles included in this plan, the Medicare Provider Reimbursement Manual (HIM-15) and GAAP. Criteria and principles will be applied using this plan as the first source, the Medicare Provider Reimbursement Manual (HIM-15) as the second source and GAAP as the third source.

(E) Ancillary. This cost component includes the following lines from the cost report version MSIR-1 (7-93): lines 62-75, 87-95, 97-103, 145-146.

(F) Asset Value. The asset value of $32,330 per bed is used in calculating the Fair Rental Value System. The asset value consists of a bed cost and a land cost. The bed cost was based upon the national average cost of a nursing facility bed, without land cost, adjusted for the city index for Kansas City and St. Louis utilizing the 1994 R.S. Means Building Construction Cost Data. The land value was based upon a study of land costs for nurisng facilties being approved for construction by the Certficate of Need program in Missouri.

(G) Average Private Pay Rate. The usual and customary charge for private patient determined by dividing total private patient days of care into private patient revenue net of contractual allowances and bad debt expense for the same service that is included in the Medicaid reimbursement rate. This excludes negotiated payment methodologies with State or Federal agencies such as the Veteran's Administration or the Missouri Department of Mental Health.

(H) Capital. This cost component will be calculated using a Fair Rental Value System. The fair rental value is reimbursed in lieu of the costs reported on lines 106-112 of the cost report version MSIR-1 (7-93) except for amortization of organizational costs.

(I) Capital Asset. A facility's building, building equipment, major moveable equipment, minor equipment, land, land improvements, and leasehold improvements as defined in HIM-15. Motor vehicles are excluded from this definition.

(J) Capital Asset Debt. The debt related to the capital assets as determined from the desk audited and/or field audited cost report.

(K) Ceiling. The ceiling is determined by applying a percentage to the median per diem for the patient care, ancillary and administration cost components. The percentage is 120% for patient care, 120% for ancillary and 110% for administration.

(L) Certified Bed. Any nursing facility or hospital based bed that is certified by the Division of Aging or Department of Health to participate in the Medicaid Program.

(M) Change of Ownership. A change in ownership, control, operator or leasehold interest, for any facility certified for participation in the Medicaid Program.

(N) Cost Components. The groupings of allowable costs used to calculate a facility's per diem rate. They are patient care, ancillary, capital and administration. In addition, a working capital allowance is provided.

(O) Cost Report. The Financial and Statistical Report for Nursing Facilities, required attachments as specified in paragraph (10)(A)8. of this plan and all worksheets supplied by the Division for this purpose. The cost report shall detail the cost of rendering both covered and non-covered services for the fiscal reporting period in accordance with this plan, cost report instruction and on forms or diskettes provided by and/or as approved by the Division.

(P) Databank. The data from the desk audited and/or field audited 1992 cost report excluding hospital based, state operated and pediatric nursing facilities. This data is adjusted for the HCFA Market Basket Index for 1993 of 3.9%, 1994 of 3.4% and nine months of 1995 of 3.3%, for a total adjustment of 10.6%. If a facility has more than one cost report with periods ending in calendar year 1992, the cost report covering a full twelve (12) month period ending in calendar year 1992 will be used. If none of the cost reports cover a full twelve (12) months, the cost report with the latest period ending in calendar year 1992 will be used. Any changes to the desk audited and/or field audited 1992 cost reports made after the effective date of this plan will not be included in the data bank.

(Z) Fair Rental Value System. The methodology used to calculate the reimbursement of capital.

(AA) Field Audit. An on-site audit of the nursing facility's records performed by the Department or its authorized agent.

(BB) Generally Accepted Accounting Principles (GAAP). Accounting conventions, practices, methods, rules and procedures necessary to describe accepted accounting practice at a particular time as established by the authoritative body establishing such principles.

(CC) HCFA Market Basket Index. An index showing nursing home market basket indexes. The index is published quarterly by DRI/McGraw Hill. The table used in this plan is titled "DRI Health Care Cost - National Forecasts, HFCA Nursing Home without Capital Market Basket."

(DD) Hospital Based. Any nursing facility bed licensed and certified by the Department of Health.

(EE) Interim Rate. The interim rate is the sum of 100% of the patient care cost component ceiling, 90% of the ancillary and administration cost component ceilings, 95% of the median per diem for the capital cost component, and the working capital allowance using the interim rate cost component. The median per diem for capital will be determined from the capital component per diems of providers with prospective rates in effect on January 1, 1995.

(FF) Licensed Bed. Any Skilled Nursing Facility or Intermediate Care Facility bed meeting the licensing requirement of the Division of Aging or the Missouri Department of Health.

(GG) Median. The median cost is the middle value in a distribution, above and below which lie an equal number of values. This distribution is based on the databank.

(HH) Nursing Facility (NF). Effective October 1, 1990, Skilled Nursing Facilities, Skilled Nursing Facilities/Intermediate Care Facilities and Intermediate Care Facilities as defined in Chapter 198 RSMo participating in the Medicaid Program will all be subject to the minimum Federal requirements found in section 1919 of the Social Security Act.

(II) Occupancy Rate. A facility's total actual patient days divided by the total bed days for the same period as determined from the desk audited and/or field audited cost report. For a distinct part facility that completes a worksheet one (1) of cost report, version MSIR (7-93), determine the occupancy rate from the total actual patient days from the certified portion of the facility divided by the total bed days from the certified portion for the same period, as determined from the desk audited and/or field audited cost report.

(JJ) Patient Care. This cost component includes the following lines from the cost report version MSIR-1 (7-93): lines 45-60,77-85.

(KK) Patient Day. The period of service rendered to a patient between the census-taking hour on two (2) consecutive days. Census shall be taken in all facilities at midnight each day and a census log maintained in each facility for documentation purposes. "Patient day" includes the allowable temporary leave-of-absence days per subsection (5)(D) and hospital leave days per subsection (5)(M). The day of discharge is not a patient day for reimbursement unless it is also the day of admission.

(LL) Per Diem. The daily rate calculated using this plan's cost components and used in the determination of a facility's prospective and/or interim rate.

(MM) Provider or Facility. A nursing facility with a valid Medicaid participation agreement with the Department of Social Services for the purpose of providing nursing facility services to Title XIX eligible recipients.

(NN) Prospective Rate. The rate determined from the rate setting cost report.

(OO) Rate Setting Period. The full twelve (12) month period in which a facility's prospective rate is determined. The rate setting period for a facility is determined from applicable plans on or after July 1, 1990.

(PP) Reimbursement Rate. A prospective or interim rate.

(QQ) Related Parties. Parties are related when any one (1) of the following circumstances apply:

1. An entity where, through its activities, one (1) entity's transactions are for the benefit of the other and such benefits exceed those which are usual and customary in such dealings.

2. An entity has an ownership or controlling interest in another entity; and the entity, or one (1) or more relatives of the entity, has an ownership or controlling interest in the other entity. For the purposes of this paragraph, ownership or controlling interest does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking firm or insurance company unless the entity directly, or through a subsidiary, operates a facility.

3. As used in this plan, the following terms mean:

A. Indirect ownership/interest means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in an entity;

B. Ownership interest means the possession of equity in the capital, in the stock, or in the profits of an entity. Ownership or controlling interest is when an entity:

(I) Has an ownership interest totalling five percent (5%) or more in an entity;

(II) Has an indirect ownership interest equal to five percent (5%) or more in an entity. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity;

(III) Has a combination of direct and indirect ownership interest equal to five percent (5%) or more in an entity;

(IV) Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by an entity if that interest equals at least five percent (5%) of the value of the property or assets of the entity. The percentage of ownership resulting from these obligations is deter-mined by multiplying the percentage of interest owned in the obligation by the percentage of the entity's assets used to secure the obligation;

(V) Is an officer or director of an entity; or

(VI) Is a partner in an entity that is organized as a partnership.

C. Relative means person related by blood, adoption or marriage to the fourth degree of consanguinity.

(RR) Replacement Beds. Newly constructed beds never certified for Medicaid or previously licensed by the Division of Aging or the Department of Health and put in service in place of existing Medicaid beds. The number of replacement beds being certified for Medicaid shall not exceed the number of beds being replaced.

(SS) Renovations/Major Improvements. Capital cost incurred for improving a facility excluding replacement beds and additional beds.

(TT) Restricted Funds. Funds, cash, cash equivalents or marketable securities, including grants, gifts, taxes and income from endowments which must only be used for a specific purpose designated by the donor.

(UU) Total Facility Size. Facility size plus increases minus decreases of licensed nursing facility beds plus calculated bed equivalents for renovations/major improvements.

(VV) Unrestricted Funds. Funds, cash, cash equivalents or marketable securities, including grants, gifts, taxes and income from endowments, that are given to a provider without restriction by the donor as to their use.

(5) Covered Supplies, Items and Services. All supplies, items and services covered in the reimbursement rate must be provided to the resident as necessary. Supplies and services which would otherwise be covered in a reimbursement rate but which are also billable to the Title XVIII Medicare Program must be billed to that program for facilities participating in the Title XVIII Medicare Program. Covered supplies, items and services include, but are not limited to, the following:

(A) Services, items and covered supplies required by federal or state law or plan which must be provided by nursing facilities participating in the Title XIX Program;

(B) Semi-private room and board;

(C) Private room and board when it is necessary to isolate a recipient due to a medical or social condition examples of which may be contagious infection, loud irrational speech, etc.;

(D) Temporary leave of absence days for Medicaid recipients, not to exceed twelve (12) days for the first six (6) calendar months and not to exceed twelve (12) days for the second six (6) calendar months. Temporary leave of absence days must be specifically provided for in the recipient's plan of care and prescribed by a physician. Periods of time during which a recipient is away from the facility visiting a friend or relative are considered temporary leaves of absence;

(E) Provision of personal hygiene and routine care services furnished routinely and uniformly to all residents;

(F) All laundry services, including personal laundry;

(G) All dietary services, including special dietary supple-ments used for tube feeding or oral feeding. Dietary supplements prescribed by a physician are also covered items;

(H) All consultative services required by federal or state law or plans;

(I) All therapy services required by federal or state law or plans;

(J) All routine care items including, but not limited to, those items specified in Appendix A to this plan;

(K) All nursing services and supplies including, but not limited to, those items specified in Appendix A to this plan;

(L) All non-legend antacids, non-legend laxatives, non-legend stool softeners and non-legend vitamins. Providers may not elect which non-legend drugs in any of the four (4) categories to supply; any and all must be provided to residents as needed and are included in a facility's reimbursement rate; and

(M) Hospital leave days as defined in 13 CSR 70-10.070.

(6) Non-Covered Supplies, Items and Services. All supplies, items and services which are either not covered in a facility's reimbursement rate or are billable to another program in Medicaid, Medicare or other third party payor. Non-covered supplies, items and services include, but are not limited to, the following:

(A) Private room and board unless it is necessary to isolate a recipient due to a medical or social condition, examples of which may be contagious infection, loud irrational speech, etc. Unless a private room is necessary due to such a medical or social condition, a private room is a non-covered service and a Medicaid recipient or responsible party may therefore pay the difference between a facility's semi-private charge and its charge for a private room. Medicaid recipients may not be placed in private rooms and charged any additional amount above the facility's Medicaid reimbursement rate unless the recipient or responsible party specifically requests in writing a private room prior to placement in a private room and acknowledges that an additional amount not payable by Medicaid will be charged for a private room;

(B) Supplies, items and services for which payment is made under other Medicaid Programs directly to a provider or providers other than providers of the nursing facility services; and

(C) Supplies, items and services provided non-routinely to residents for personal comfort or convenience.

(7) Allowable Cost Areas.

(A) Compensation of Owners.

1. Compensation of services of owners shall be an allowable cost area. Reasonableness of compensation shall be limited as prescribed in subsection (8)(Q).

2. Compensation shall mean the total benefit, within the limitations set forth in this plan and consistent with and as defined by the Medicare Provider Reimbursement Manual, Part 1, Chapter 9, received by the owner for the services rendered to the facility. This includes direct payments for managerial, administrative, professional and other services, amounts paid for the personal benefit of the owner, the cost of assets and services which the owner receives from the provider, and additional amounts determined to be the reasonable value of the services rendered by sole proprietors or partners and not paid by any method previously described in this plan. Compensation must be paid (whether in cash, negotiable instrument, or in kind) within seventy-five (75) days after the close of the period in accordance with the guidelines published in the Medicare Provider Reimbursement Manual, Part 1, Section 906.4.

(B) Covered services and supplies as defined in section (5) of this plan.

(C) Capital Assets

1. Capital Assets shall include historical costs that would be capitalized under GAAP. For example, historical costs would include but not limited to, architectural fees, related legal fees, interest and taxes during construction.

2. For purposes of this plan, any asset or improvement costing greater than one thousand dollars ($1,000) and having a useful life greater than one (1) year in accordance with American Hospital Association depreciable guidelines, shall be capitalized.

3. In addition to the American Hospital Association depreciable guidelines, mattresses shall be considered a capitalized asset and shall have a three (3) year useful life.

(D) Depreciation - Vehicle.

1. An appropriate allowance for depreciation on vehicles which are a necessary part of the operation of a nursing facility is an allowable cost. One vehicle per 60 licensed beds is allowable. For example, one vehicle is allowed for a facility with 0-60 licensed beds, two vehicles are allowed for a facility with 61-120 licensed beds, etc. Depreciation is treated as an administration cost and is reported on line 139 of the cost report, version MSIR-1 (7-93).

2. The depreciation must be identifiable and recorded in the provider's accounting records, based on the basis of the vehicle and prorated over the estimated useful life of the vehicle in accordance with American Hospital Association depreciable guidelines using the straight line method of depreciation from the date initially put into service.

3. The basis of vehicle cost at the time placed in service shall be the lower of:

A. the book value of the provider;

B. fair market value at the time of acquisition; or

C. the recognized IRS tax basis.